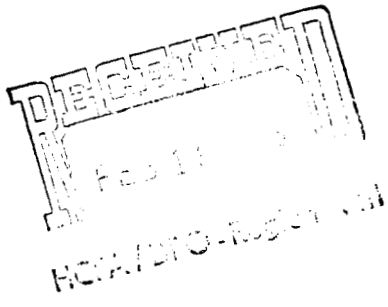
Attachment 4.19B,
Methods & Standards
for Establishing
Payment Rates,
Service 6.d,
Clinical Social
Workers' Services

* The statistically significant volume of services is based upon a study conducted by GLC Associates. The study was provided to the Department by the Montana Chapter of the National Association of Social Workers. The study was used by the Department in developing a fee schedule that is consistent with efficiency, economy and quality of care. The fee schedule is sufficient to enlist enough providers to assure services are available to recipients at least to the extent that those services are available to the general population.



MONTANA

I. Reimbursement for Licensed Professional Counselors' Services shall be the lowest of the following:

A. For those services not also covered by Medicare:

1. the provider's actual (submitted) charge for the services; or
2. the Department's fee schedule.

B. For those services also covered by Medicare.

1. the provider's actual (submitted) charge for the service;
2. the amount allowable for the same service under Medicare; or
3. the Department's fee schedule.

II. In determining upper limits of reimbursement for Licensed Professional Counselor Services:

A. The provider's actual charge is the amount submitted on the claim to Medicaid.

B. The amount allowable for the same service under Medicare is obtained from the Medicare Part B Carrier.

C. The Department's fee schedule has two components:

1. Billing codes are in place for individual counseling, group counseling and family therapy. Fees have been established under licensed social workers program.

2. Appraisals and consultations fees shall not exceed the individual counseling rate as provided in C1.

MONTANA

Montana Medicaid applies the generic term Mid-level Practitioner to physician assistants and advanced practice nurses. Advanced practice nurses include certified nurse midwife, nurse anesthetist, nurse practitioner, etc.

I. Reimbursement for Mid-level Practitioners' Services for immunizations; family planning; radiology; pathology and laboratory and cardiography and echocardiography services; services billed under HCPCS J codes; and, for EPSDT services shall be the lower of:

   A. The provider's usual and customary charge for the service; or

   B. Those fees provided and reimbursed for under Attachment 4.19B, Methods & Standards for Establishing Payment Rates for Service 5(a), Physicians' Services.

II. Reimbursement for all Mid-level Practitioners' Services not listed in I. above shall be the lower of:

   A. The provider's usual and customary charge for the service; or

   B. 90% of those fees provided and reimbursed for under Attachment 4.19B, Methods & Standards for Establishing Payment Rates for Service 5(a), Physicians' Services.

MONTANA

I. Reimbursement for Psychologists' Services not specified in Part II below shall be the lower of:

A. The provider's usual and customary charge for the service; or

B. 90% of those fees provided and reimbursed for under Attachment 4.19B, Methods & Standards for Establishing Payment Rates for Service 5(a), Physicians' Services.

II. Medicaid fees have been established for the following ICD-9 Diagnoses:

290-299	300	301	302	306	307	308	309	310	311
	312	313	314	316					

Attachment 4.19B

Methods and Standards
For Establishing
Payment Rates
Service 6d
Home Infusion Therapy
Nursing Services

Reimbursement for nursing services for the administration of home infusion therapy shall not exceed the lowest of:

1. The provider's actual charge for the service;

2. The Department's fee schedule.

   The Department's fee schedule is based on the statewide average hourly wage (including taxes and benefits) of registered nurses as reported to the Department on a survey of home health and hospital providers.

MONTANA

1. Reimbursement for Home Health Services shall be the lower of the following:

   A. The provider's actual (submitted) charge for the service; or

   B. $60.43 for skilled nursing

2. Home Health Aide Services shall be the lower of the following:

   A. The provider's actual (submitted) charge for service; or

   B. $26.99 for home health aide services.

MONTANA

I. Reimbursement for Durable Medical Equipment and Supplies shall be the lowest of the following:

A. For those services not also covered by Medicare:

1. the provider's actual (submitted) charge for the service; or
2. the Department's fee schedule.

B. For those services also covered by Medicare:

1. the provider's actual (submitted) charge for the service;
2. the amount allowable for the same service under Medicare; or
3. the Department's fee schedule.

II. In determining upper limits of reimbursement for Durable Medical Equipment and Supplies:

A. The provider's actual charge is the amount submitted on the claim to Medicaid.

B. The amount allowable for the same service under Medicare is obtained from the Medicare part B Carrier.

C. The Department's fee schedule has three components:

1. Specified fees for:

Durable Medical Equipment and Supplies for which there is not a statistically significant volume* or which includes variable modifications. These are reimbursed at 90% of billed charges.

2. Wheelchairs and accessories will be reimbursed at 83% of manufacturer's list price.

3. Rental items listed as 'capped' rental under Medicaid are limited to 12 months rental. Rental for items needing frequent servicing as classified by Medicare can be rented as long as the medical necessity exists. Other rentals are limited to Medicaid purchase fee or if no fee exists the suppliers purchase price as long as it is reasonable.

(a) rental fees include all necessary supplies needed to operate rented equipment for the month.

* A statistically significant volume of service is a number of services billed to the Medicaid program during a calendar year which will provide sufficient data for calculating a reasonable prevailing charge, using the Medicaid methods. The data for items which fifty bills have been received in a calendar year will be reviewed for possible fee determination within the state fiscal biennium.

III. Reimbursement for home infusion therapy shall not exceed the lowest of:

A. The provider's usual and customary charge of the therapy to the general public; or

B. The Medicaid fee established as a daily rate for home infusion therapy providers.

Daily rates for various therapies were established based on the usual and customary charges reported by home infusion therapy providers in the State of Montana. The daily rate for each therapy was derived by averaging the individual provider charges. The Department worked with providers to reach agreement on reimbursement for individuals infusion therapies.

MONTANA

1. Reimbursement for Home Health Services shall be the lower of the following:

   A. The provider's actual (submitted) charge for the service; or

   B. $60.43 for physical therapy, speech therapy, and occupational therapy.

Attachment 4.19B,
Methods & Standards
for Establishing
Payment Rates,
Service 8,
Private Duty Nursing
Services

MONTANA

I. Reimbursement for Private Duty Nursing Services shall be the lowest of the following:

A. The provider's actual (submitted) charge for the services.

B. The Department's fee schedule.

II. In determining upper limits for reimbursing Private Duty Nursing Services:

A. The provider's actual charge is the amount submitted on the claim to Medicaid.

B. The amount allowable for the same service under Medicare is obtained from the Medicare Part B Carrier.

C. The Department's fee schedule has two components:

1. Specified fees per selected procedure:

Procedures for which there is a statistically significant volume* during the calendar year preceding the fiscal review year have specified fees established. Such fees in force are a 33.1% increase over the fees in effect in June, 1980, except for additional adjustments for selected crucial procedures.

2. Percentage of billed charges per selected procedure:

Procedures for which there is not a statistically significant volume or with variable modifiers reflecting exceptional difficulty are reimbursed at 65.2% of billed charges.

* A statistically significant volume of services is a number of services billed to the medicaid program during a calendar year which will provide sufficient data for calculating a reasonable prevailing charge, using the Medicaid methods. The data for items which fifty bills have been received in a calendar year will be reviewed for possible fee determination within the state fiscal biennium.